

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03064

3087

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lusby</u>		c. LENGTH OF STAY IN 1b <u>49 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>W. Charles Blackburn</u>		4. DATE OF DEATH Month <u>Mar</u> Day <u>15</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 8, 1879</u>
9. AGE (In years last birthday) <u>81</u> yrs.		10. IF UNDER 1 YEAR: Months <u>8</u> Days <u>15</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Calvert Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Blackburn</u>		14. MOTHER'S MAIDEN NAME <u>Sarah Dixon</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Edward Blackburn, Lusby, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serious Dehydration -</u> 304X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiac Decomposition</u> DUE TO (c) <u>Malnutrition</u>		INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>2 weeks</u> <u>4 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 2, 1959</u> to <u>March 15, 1960</u> , that I last saw the deceased alive on <u>March 6, 1960</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Page C. Jett</u>		ADDRESS (Street, city or town, state) DATE SIGNED <u>Prince Frederick 3/16/60</u>	
PHYSICIAN'S NAME (Type) <u>Page C. Jett</u>		M.D. <u>Maryland</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar 18, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Lusby, Calvert Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Harkness, Jr., Mutual, Md.</u>		ADDRESS	
24a. REC'D BY REGISTRAR <u>MAR 21 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED
NAME
BORN
DIED

SEX

AGE

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

SIGNATURE

3088

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>				c. LENGTH OF STAY IN 1b <u>14 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Aden</u> Middle <u>Ezekiel</u> Last <u>Bowen</u>				4. DATE OF DEATH Month <u>March</u> Day <u>27</u> Year <u>19 60</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1872</u>	
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>			
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Agabus Bowen</u>				14. MOTHER'S MAIDEN NAME <u>Celeste Gibson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>- - -</u>		17. INFORMANT <u>Wayne Bowen</u> Address <u>Huntingtown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperextension R.V.R</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-8-</u> , 19 <u>40</u> , to <u>27 Mar</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>27 Mar</u> , 19 <u>60</u> , and that death occurred at <u>7:15</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Maryland</u> DATE SIGNED <u>Mar. 27, 1960</u>							
ACTUAL SIGNATURE <u>G. J. Weems</u> M.D.							
PHYSICIAN'S NAME (Type) <u>G. J. Weems</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Mar. 29, 1960</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Huntingtown Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Huntingtown, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home Owings Md.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAR 31 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kram</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician. After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

2022

W. J. ...
T. A. ...
J. M. ...
C. M. ...
D. M. ...
E. M. ...
F. M. ...
G. M. ...
H. M. ...
I. M. ...
J. M. ...
K. M. ...
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O. M. ...
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Q. M. ...
R. M. ...
S. M. ...
T. M. ...
U. M. ...
V. M. ...
W. M. ...
X. M. ...
Y. M. ...
Z. M. ...

CONSENT

Form with multiple horizontal lines for text entry, including fields for name, date, and other details.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3089

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03066

Reg. Dist. No.

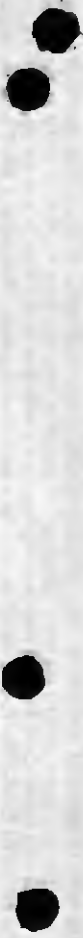
1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co. H</u>				e. STREET ADDRESS <u>Benedict</u>			
3. NAME OF DECEASED (Type or print) <u>Joseph Richard Cheseldine</u>				4. DATE OF DEATH Month <u>3</u> Day <u>8</u> Year <u>1960</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/29/91</u>	9. AGE (In years, last birthday) <u>68</u> yrs.	10. F UNDER 1 YEAR Months <u>0</u> Days <u>0</u>	11. IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>	12. CITIZEN OF WHAT COUNTRY?
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Waiter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>			
11. BIRTH PLACE (State or foreign country) <u>Md</u>				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME <u>Henry Cheseldine</u>				14. MOTHER'S MAIDEN NAME <u>Emily Mapen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mary A Cheseldine Benedict, md</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial infarction</u> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had been very sick for several days</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year <u>14</u> <u>19</u> <u>60</u> Hour <u>6</u> p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>H W Ward</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Joseph</u>		22d. LOCATION (City, town, or county) (State) <u>Morganza, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Clarke Mattingley Leonardtown, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 5 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple horizontal lines for text entry, including fields for name, address, date, and cause of death.

REGISTERED IN THE
GENERAL REGISTRY OFFICE
LONDON



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the medical director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3090

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03067

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Michael</u> First <u>L</u> Middle <u>Robert</u> Last 4. DATE OF DEATH Month <u>3</u> Day <u>9</u> Year <u>1960</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>Feb 6 1959</u> 9. AGE (In years last birthday) yrs. <u>3</u> 10. IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u> 11. IF UNDER 24 HRS. Hours <u>3</u> Min. <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>James Coby</u>		14. MOTHER'S M maiden name <u>Esther Clemons King</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>James Coby</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Upper Respiratory Disease</u> <u>475X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Found dead in bed</u>		INTERVAL BETWEEN ONSET AND DEATH	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>7</u> a. m. <u>39</u> 19 <u>60</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. City or town <u>Prince Frederick</u> (County) <u>Calvert</u> (State) <u>Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>3-11-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		22d. LOCATION (City, town, or county) <u>Prince Frederick</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Sewell</u> ADDRESS <u>Prince Frederick</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 14 '60</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

2064212XV4

1. Name of deceased: _____

2. Sex: _____

3. Age: _____

4. Date of death: _____

5. Place of death: _____

6. Cause of death: _____

7. Signature of medical examiner: _____

8. Signature of coroner: _____

9. Signature of physician: _____

10. Signature of funeral director: _____

11. Signature of next of kin: _____

12. Signature of witness: _____

13. Signature of witness: _____

14. Signature of witness: _____

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99. Signature of witness: _____

100. Signature of witness: _____

03068

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Q & Q</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN lb <u>8 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>James Wesley</u> First <u>Wesley</u> Middle <u>Crosby</u> Last <u>Crosby</u>		4. DATE OF DEATH <u>3</u> Month <u>14</u> Day <u>19</u> Year <u>60</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 15, 1900</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Walter Crosby</u>		14. MOTHER'S MAIDEN NAME <u>Lillian A. Sheehan</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-28-8808</u>	
17. INFORMANT <u>James W Crosby Jr</u> Address <u>Bristol Md</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>3/14</u> , 19 <u>60</u> , to <u>3/14</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>3/14</u> , 19 <u>60</u> , and that death occurred at <u>1030 P</u> .M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>H W Ward</u>		ADDRESS (Street, city or town, state) <u>Owings Md</u> DATE SIGNED <u>3/14/60</u>	
PHYSICIAN'S NAME (Type) <u>H. W. WARD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-17-60</u>	22c. NAME OF CEMETERY OR CREMATORIUM <u>Friendship</u>	22d. LOCATION (City, town, or county) <u>Friendship Md</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hutchins Funeral Home</u> ADDRESS <u>Owings Md</u>		24a. REC'D BY REGISTRAR <u>DATE MAR 18 '60</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

NAME

RESIDENCE

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

OCCUPATION

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF ARRIVAL

PLACE OF ARRIVAL

DATE OF DEPARTURE

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DATE OF ARRIVAL

PLACE OF ARRIVAL

3092

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u>		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince George's</u>		c. LENGTH OF STAY in 1b <u>Ches. Beach</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Calvert Co. H</u>		d. STREET ADDRESS <u>1</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Summie E. Esper</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 18-1871</u>
9. AGE (In years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Domestic</u>	
11. BIRTHPLACE (State or foreign country) <u>Md - Forestville</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John T. Brown</u>		14. MOTHER'S MAIDEN NAME <u>Catherine E. Beane</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Hospital Chart</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio vascular Renal Disease</u> <u>442 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cere</u> (c) <u>Eye</u> DUE TO storing the underlying cause lost.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Tell 11/6/59 and fractured hip left</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Tell at home</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a. m. <u>11/6</u> 19 <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Ches. Beach Calvert Md</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H W Wood</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DATE SIGNED <u>3/15/60</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-22-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Forest Mem. Meth. Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Forestville Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Summers Bros.</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 21 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>William S. Harris</u>			

TO THE MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If delay is necessary, please enclose the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Pages 1 and 2 must be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please advise the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM-3. Page 5 may be retained in the files.

TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

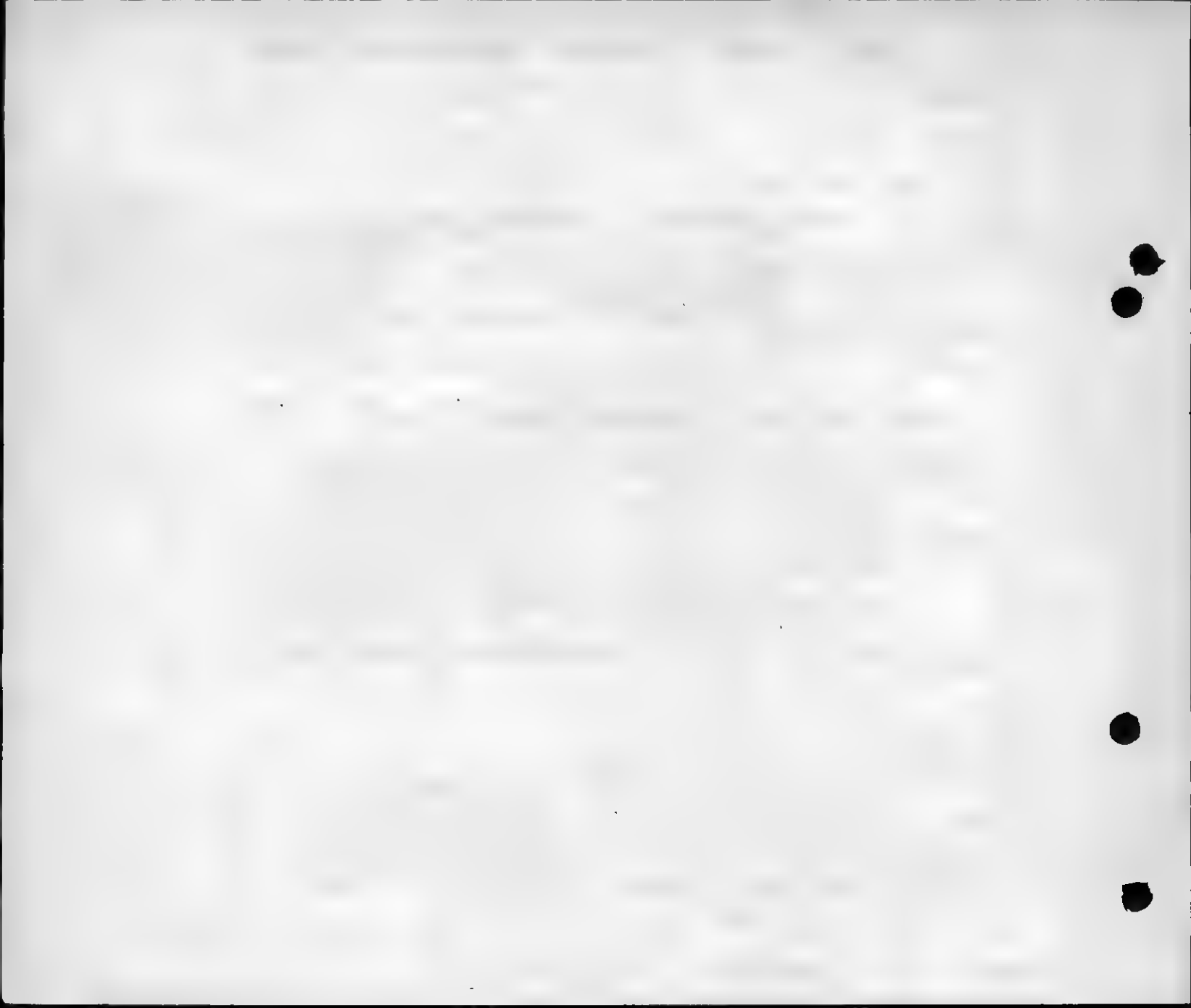
3093

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03070

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Priddy</u>			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Priddy</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>DRUGCELLA</u>			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) <u>Drucella</u> First <u>Johnson</u> Middle Last			4. DATE OF DEATH <u>3</u> Month <u>27</u> Day <u>1960</u> Year		
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/1</u>	9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
13. FATHER'S NAME <u>Wm. T. Johnson</u>			14. MOTHER'S MAIDEN NAME <u>Ann Weems</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mary O. Johnson, Priddy, MD</u> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular finding, drugs</u> <u>442X</u> DUE TO <u>eye</u> Conditions, if any, which gave rise to immediate cause (b) <u>eye</u> (c), stating the underlying cause lost. (c) <u>eye</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Had a pain in chest and died in a few min.</u>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)					
20c. TIME OF INJURY Month, Day, Year <u>11/30</u> Hour a. m. <u>3/21</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	
20f. City or town <u>Priddy</u>		20g. County <u>Calvert</u>		20h. State <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>3/21/60</u>	
EXAMINER'S NAME (Type) <u>H. W. Ward</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-25-60</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>	
22d. LOCATION (City, town, or county) <u>Priddy</u>		(State) <u>MD</u>		23. FUNERAL DIRECTOR'S SIGNATURE <u>P. E. Seavelle, Prince Fred.</u> ADDRESS	
24a. REC'D BY REGISTRAR <u>DATE 2 8 '60</u>		24b. REGISTRAR'S SIGNATURE <u>CLARA S. Kline</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03071

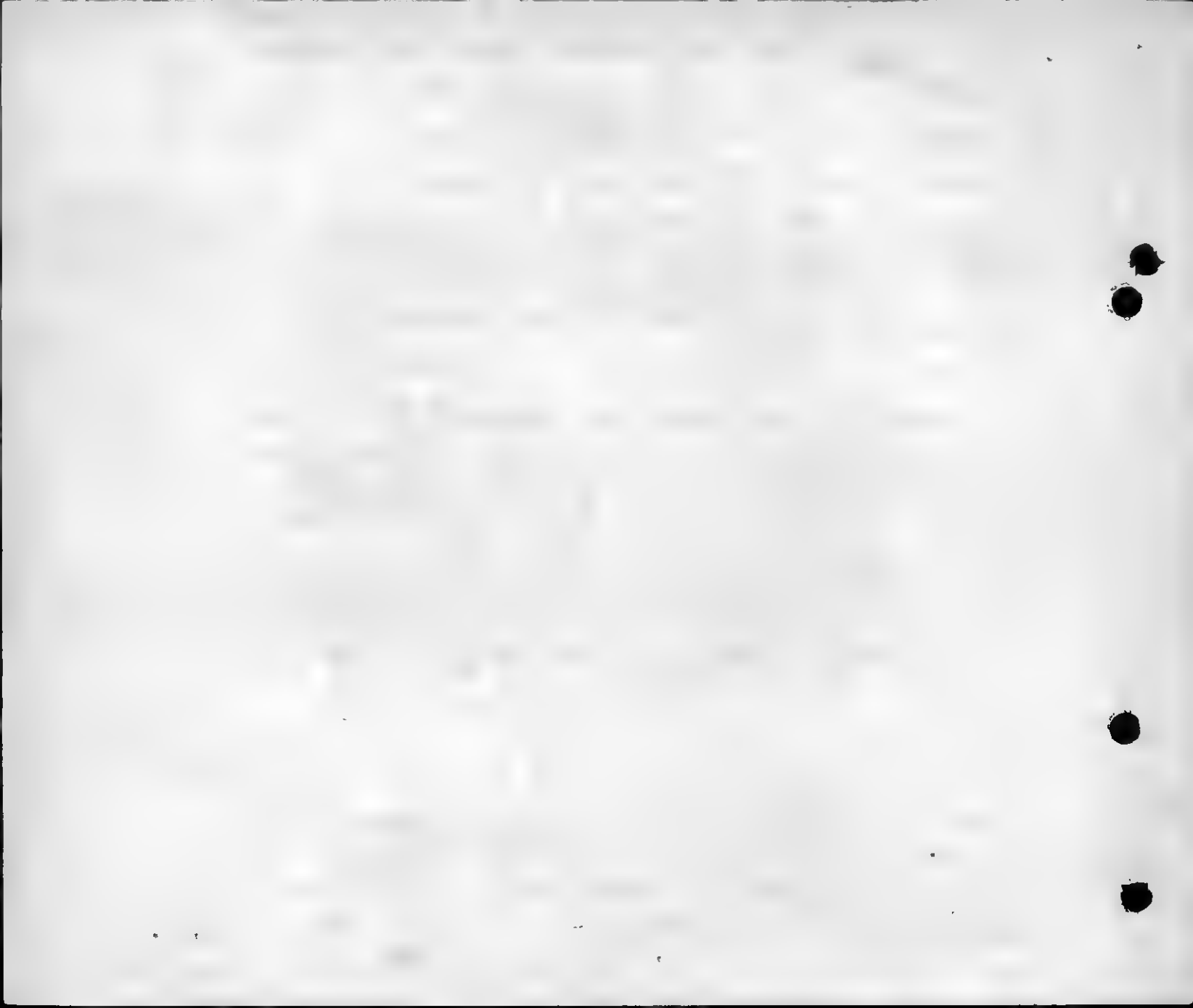
3094

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabot</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cabot</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. LENGTH OF STAY IN 1b <u>Franklin</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cabot Co H</u>		d. STREET ADDRESS <u>Franklin</u>	
3. NAME OF DECEASED (Print name) First <u>Ernest</u> Middle <u>Jones</u> Last <u>Jones</u>		4. DATE OF DEATH Month <u>3</u> Day <u>23</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>8/18/83</u>	9. AGE (In years last birthday) <u>76</u> yrs.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Postmaster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Post office</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William W Whittingham</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Olshin</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>WW Whittingham</u>	
17. INFORMANT <u>WW Whittingham</u>		Address <u>Balt 29104</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>10 yrs</u> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Fractured hip 2/13/60</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her room at CCH Home Cabot Md</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>2</u> p. m. <u>2/3</u> 19 <u>60</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, hotel, office bldg., etc.) <u>Home</u>		20f. CITY OR TOWN (County) (State) <u>Prince Frederick Cabot Md</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
ACTUAL SIGNATURE <u>H W Ward</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>3/23/60</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore 7 Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Witzke Funeral Directors, 4101 Edmondson Ave</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 31 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be examined within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Pages 1 and 2 with the registrar prior to burial, cremation, or removal.



3095
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Cabret</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <i>Md</i> b. COUNTY <i>Cabret</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Barstow</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Cabret County Hospital</i>		d. STREET ADDRESS <i>—</i>	
3. NAME OF DECEASED (Type or print) <i>Norman R. Whiter</i>		4. DATE OF DEATH <i>Mar. 1, 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>May 5, 1914</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Self-employed farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farming - Painting</i>	9. AGE (In years last birthday) <i>45</i> yrs.
11. BIRTHPLACE (State or foreign country) <i>Cabret Co., Md</i>		12. CITIZEN OF WHAT COUNTRY <i>U.S.A.</i>	
13. FATHER'S NAME <i> Percy Whiter</i>		14. MOTHER'S MAIDEN NAME <i>Mary Ramsey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO <i>220-16-4331</i>	
17. INFORMANT <i>Harold Reid Whiter - Barstow, Md</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Carcinoma of Lung</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause/lost. (b) <i>—</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yr</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Had been operated upon several months ago</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>2/24</i> , 19 <i>60</i> to <i>3/1</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>2/29/60</i> , 19 <i>60</i> , and that death occurred at <i>8:20 A.M.</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>3/1/60</i>	
PHYSICIAN'S NAME (Type) <i>H. W. WARD</i>		M.D. <i>Owings, Md</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Mar. 4, 1960</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Asbury Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Barstow - Cabret Co - Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. Tarkenton & Son - Mutual, Md.</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>—</i>		24b. REGISTRAR'S SIGNATURE <i>—</i>	
DATE <i>MAR 3 '60</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached from the certificate as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

2096

CERTIFICATE OF DEATH

Reg. Dist. No.

04324

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert Co. Hospital</u>		d. STREET ADDRESS <u>Island Creek</u>	
3. NAME OF DECEASED (Type or print) <u>Craig McDaniel Mason</u>		4. DATE OF DEATH Month <u>3</u> Day <u>31</u> Year <u>1960</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-4-60</u>
9. AGE (In years last birthday) yrs <u>2</u> Months <u>27</u> Days <u>27</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Winslow Mason</u>		14. MOTHER'S MAIDEN NAME <u>Urdina Johnson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Winslow Mason, Island Creek</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>47-X</u> DUE TO (c) <u>—</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4 Jan</u> , 19 <u>60</u> , to <u>30 Nov</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>30 Nov</u> , 19 <u>60</u> , and that death occurred at <u>4A</u> M., from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>[Signature]</u> M.D.			
PHYSICIAN'S NAME (Type)			
22a. BURIAL CREMATION, REMOVAL (Specify) <u>4-1-60</u>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <u>Brooks Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Calvert Co. Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>P.E. Sewell</u>		ADDRESS <u>Prince Frederick</u>	
24a. REC'D BY REGISTRAR DATE <u>APR 7 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kneass</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. After the attending physician and completed certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2064329XV7



3097

CERTIFICATE OF DEATH

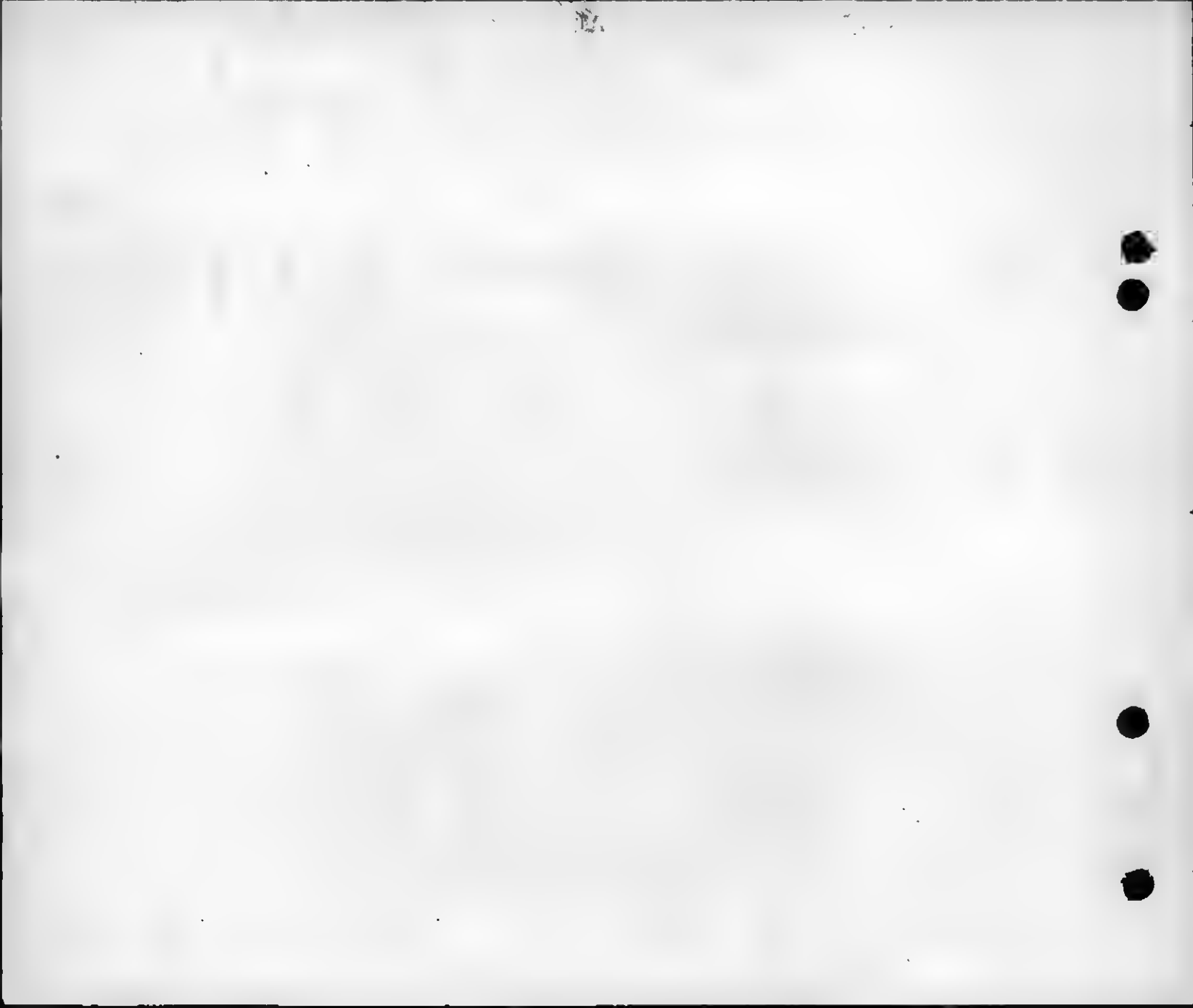
03073

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Island Creek</u>	
3. NAME OF DECEASED (Type or print) First <u>Anna</u> Middle <u>M.</u> Last <u>PARDOE</u>		4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 1, 1888</u>
9. AGE (In years last birthday) <u>72</u> yrs		10. IF UNDER 1 YEAR, IF UNDER 24 HRS Months _____ Days _____ Hours _____ Min _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Joseph F. Himmer</u>		14. MOTHER'S MAIDEN NAME <u>Barbara Schweitzer</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Lawrence Pardoe, Island Creek Md.</u>		Address _____	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY ARTERY DISEASE</u> DUE TO (c) <u>Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>1955</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CARCINOMA of BREAST 1946</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____	20d. INJURY OCCURRED While _____ Not while _____ of work _____ of work _____	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>MAY 1954</u> , 1954, to <u>MARCH 9, 1960</u> , that I last saw the deceased alive on <u>MARCH 8, 1960</u> , and that death occurred at <u>6:30</u> M., from the causes and on the date stated above			
ACTUAL SIGNATURE <u>Page Jett</u> M. D. <u>Prince Frederick, Md.</u>		DATE SIGNED _____	
PHYSICIAN'S NAME (Type) <u>PAGE JETT</u>		<u>PRINCE FREDERICK, MD</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Mar. 13, 1960</u>	22c. NAME OF CEMETERY OR CREMATORY <u>National Memorial Cem.</u>	22d. LOCATION (City, town, or county) <u>Island Creek Calvert Co., Md.</u> (State) _____
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Hartman</u>		ADDRESS <u>Island Creek, Md.</u>	
24a. REC'D BY REGISTRAR <u>MAR 14 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Charles S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital attending physician.

TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03074

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cabert</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mutual</u> c. LENGTH OF STAY IN 1b <u>1 yr - 1 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) _____		2. USUAL RESIDENCE (Where deceased lived. If institution/Residence before admission) a. STATE <u>Tenn</u> b. COUNTY <u>Hawken</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Churchill</u> d. STREET ADDRESS <u>04X-1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Betty Martha Lee</u> First <u>Lee</u> Middle <u>Warren</u> Last <u>Warren</u>		4. DATE OF DEATH Month <u>3</u> Day <u>19</u> Year <u>1960</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 16, 1905</u> 9. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tenn</u>	
11. BIRTHPLACE (State or foreign country) <u>Tenn</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Samuel Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Elyzabeth Carr</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Mrs. Warren, Mutual</u>		Address <u>Ind</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac failure</u> <u>782.4</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Was reading clock, and was found dead on sofa</u>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OR DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:30</u> min. <u>3/19</u> 19 <u>60</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Mutual Cabert</u> (County) <u>Ind</u> (State) <u>Tenn</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Removed</u>		22b. DATE THEREOF <u>Mar 20, 1960</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Buffalo Cemetery</u>		22d. LOCATION (City, town, or county) <u>Bluff City - Tenn.</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harkness & Son - Mutual, Ind</u>		24a. REC'D BY REGISTRAR <u>William S. Kneass</u> 24b. REGISTRAR'S SIGNATURE _____	
DATE <u>MAR 22 '60</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the County Health Officer. TO CHIEF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the County Health Officer. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

3005

Form with multiple lines for text entry, including fields for patient information, medical history, and cause of death.

MASSACHUSETTS DEPARTMENT OF HEALTH - DAY 1900

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03075

3099

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Calvert</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prince Frederick</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Plum Point</u>	
c. LENGTH OF STAY IN 1b <u>4 hours</u>		d. STREET ADDRESS <u>1</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Calvert County Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>SAMUEL</u> Middle <u>HAMILTON</u> Last <u>WILSON</u>		4. DATE OF DEATH Month <u>March</u> Day <u>30</u> Year <u>1960</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 1, 1874</u>
9. AGE (In years last birthday) <u>86</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Millard Wilson</u>		14. MOTHER'S MAIDEN NAME <u>Emma Essex</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u> - - - - </u>	
17. INFORMANT <u>Mrs. Daisy Smack</u>		Address <u>Huntingtown, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral accident</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that I attended the deceased from <u>2-10-1948</u> to <u>3-20-1960</u> , that I last saw the deceased alive on <u>3-18-1960</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Huntingtown, Maryland</u> DATE SIGNED <u>3/21/60</u>			
ACTUAL SIGNATURE <u>G. J. Weems</u> PHYSICIAN'S NAME (Type) <u>G. J. Weems</u>		M.D. <u> </u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-23-60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Plum Point Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Belcher's Funeral Home Owings Ind.</u>		ADDRESS <u> </u>	
24a. REC'D BY REGISTRAR DATE <u>MAR 24 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kneale</u>	

CERTIFICATE OF DEATH

2-10

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY, N.Y.

<p>1. Name of deceased: _____</p>	
<p>2. Sex: _____</p>	
<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>	
<p>5. Place of death: _____</p>	
<p>6. Cause of death: _____</p>	
<p>7. Signature of physician: _____</p>	
<p>8. Signature of registrar: _____</p>	
<p>9. Signature of informant: _____</p>	
<p>10. Signature of witness: _____</p>	
<p>11. Signature of funeral director: _____</p>	
<p>12. Signature of coroner: _____</p>	
<p>13. Signature of health officer: _____</p>	
<p>14. Signature of registrar: _____</p>	
<p>15. Signature of informant: _____</p>	
<p>16. Signature of witness: _____</p>	
<p>17. Signature of funeral director: _____</p>	
<p>18. Signature of coroner: _____</p>	
<p>19. Signature of health officer: _____</p>	
<p>20. Signature of registrar: _____</p>	
<p>21. Signature of informant: _____</p>	
<p>22. Signature of witness: _____</p>	
<p>23. Signature of funeral director: _____</p>	
<p>24. Signature of coroner: _____</p>	
<p>25. Signature of health officer: _____</p>	
<p>26. Signature of registrar: _____</p>	
<p>27. Signature of informant: _____</p>	
<p>28. Signature of witness: _____</p>	
<p>29. Signature of funeral director: _____</p>	
<p>30. Signature of coroner: _____</p>	
<p>31. Signature of health officer: _____</p>	
<p>32. Signature of registrar: _____</p>	
<p>33. Signature of informant: _____</p>	
<p>34. Signature of witness: _____</p>	
<p>35. Signature of funeral director: _____</p>	
<p>36. Signature of coroner: _____</p>	
<p>37. Signature of health officer: _____</p>	
<p>38. Signature of registrar: _____</p>	
<p>39. Signature of informant: _____</p>	
<p>40. Signature of witness: _____</p>	
<p>41. Signature of funeral director: _____</p>	
<p>42. Signature of coroner: _____</p>	
<p>43. Signature of health officer: _____</p>	
<p>44. Signature of registrar: _____</p>	
<p>45. Signature of informant: _____</p>	
<p>46. Signature of witness: _____</p>	
<p>47. Signature of funeral director: _____</p>	
<p>48. Signature of coroner: _____</p>	
<p>49. Signature of health officer: _____</p>	
<p>50. Signature of registrar: _____</p>	
<p>51. Signature of informant: _____</p>	
<p>52. Signature of witness: _____</p>	
<p>53. Signature of funeral director: _____</p>	
<p>54. Signature of coroner: _____</p>	
<p>55. Signature of health officer: _____</p>	
<p>56. Signature of registrar: _____</p>	
<p>57. Signature of informant: _____</p>	
<p>58. Signature of witness: _____</p>	
<p>59. Signature of funeral director: _____</p>	
<p>60. Signature of coroner: _____</p>	
<p>61. Signature of health officer: _____</p>	
<p>62. Signature of registrar: _____</p>	
<p>63. Signature of informant: _____</p>	
<p>64. Signature of witness: _____</p>	
<p>65. Signature of funeral director: _____</p>	
<p>66. Signature of coroner: _____</p>	
<p>67. Signature of health officer: _____</p>	
<p>68. Signature of registrar: _____</p>	
<p>69. Signature of informant: _____</p>	
<p>70. Signature of witness: _____</p>	
<p>71. Signature of funeral director: _____</p>	
<p>72. Signature of coroner: _____</p>	
<p>73. Signature of health officer: _____</p>	
<p>74. Signature of registrar: _____</p>	
<p>75. Signature of informant: _____</p>	
<p>76. Signature of witness: _____</p>	
<p>77. Signature of funeral director: _____</p>	
<p>78. Signature of coroner: _____</p>	
<p>79. Signature of health officer: _____</p>	
<p>80. Signature of registrar: _____</p>	
<p>81. Signature of informant: _____</p>	
<p>82. Signature of witness: _____</p>	
<p>83. Signature of funeral director: _____</p>	
<p>84. Signature of coroner: _____</p>	
<p>85. Signature of health officer: _____</p>	
<p>86. Signature of registrar: _____</p>	
<p>87. Signature of informant: _____</p>	
<p>88. Signature of witness: _____</p>	
<p>89. Signature of funeral director: _____</p>	
<p>90. Signature of coroner: _____</p>	
<p>91. Signature of health officer: _____</p>	
<p>92. Signature of registrar: _____</p>	
<p>93. Signature of informant: _____</p>	
<p>94. Signature of witness: _____</p>	
<p>95. Signature of funeral director: _____</p>	
<p>96. Signature of coroner: _____</p>	
<p>97. Signature of health officer: _____</p>	
<p>98. Signature of registrar: _____</p>	
<p>99. Signature of informant: _____</p>	
<p>100. Signature of witness: _____</p>	